Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HEALTHTRUST LLC
PO BOX 890008
HOUSTON TX 77289

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

TWIN CITY FIRE INSURANCE CO

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-11-1752-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier gave preauthorization 6 sessions of individual psychotherapy …"

Amount in Dispute: $888.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Agree to pay; DOS 10/18/10 not authorized end date of authorization is 10/13/10."

Response Submitted by: Twin City Fire Insurance Company; 300 S. State Street; Syracuse NY 13202

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 12, 2010	90801	Not in dispute	Not in dispute
October 18, 2010	90806	$147.56	$140.58

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. In an email dated April 16, 2012, the requestor states that payment has been received for date of service July 12, 2010; therefore, no dispute exists for CPT code 90801.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for obtaining preauthorization.
4. 28 Texas Administrative Code §134.203 sets out medical fee guidelines for workers compensation medical

services provided on or after March 1, 2008.

5. The remaining service in dispute was reduced/denied by the respondent with the following reason code(s):

   Explanation of benefits dated November 4 and 19, 2010
   - W9 – unnecessary medical treatment

   Explanation
   - W1 – WC State fee schedule

Issues

1. Did the requestor obtain preauthorization for the services in dispute?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.600 states in paragraph (c) that the carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions); (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care. Paragraph (p) states that non-emergency health care requiring preauthorization includes: (7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or Division exempted return-to-work rehabilitation program.
2. The respondent submitted copy of the Hartford's preauthorization number **04909** 1020260.01 with a Start Date of 08/13/2010 and end date of 10/22/2010 to include CPT code 90806. Therefore, recommend reimbursement for disputed date of service October 18, 2010. The maximum allowable reimbursement (MAR) is calculated according to 28 Texas Administrative Code §134.203 (c) as follows:

90806: DWC CF $54.32 ÷ Medicare CF 36.0791 x participating amount $93.37 = $140.58

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $ 140.58.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $140.58 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April , 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.